CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client | Birth Date of Client | Client ID #

Street Address | City, State, Zip

☐ **REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE**

☐ **REQUEST LACDMH TO SEND A COPY OF MY REQUESTED HEALTH INFORMATION**

Name | FAX Number (include area code)

Street Address | City, State, Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information regarding the following time period:

FROM ____/____/____ (Month / Day / Year) **TO** ____/____/____ (Month / Day / Year)

☐ **REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

COPY FEES: LACDMH MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I must be provided with a signed copy of the form.

Right to Request Review of Denial of Access - I understand that LACDMH may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a ***Request for Review of Denial of Access***. In most circumstances, LACDMH will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

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COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

SIGNATURE OF CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year

FORM(S) OF IDENTIFICATION PROVIDED:

- ☐ State Driver License _____
- ☐ State Identification Card _____
- ☐ Birth Certificate _____
- ☐ Military ID _____
- ☐ Other (Provide details) _____

FACILITY: _____

PRACTITIONER: _____ **DATE:** _____/_____/_____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at http://dmh.lacounty.gov/wps/portal/dmh or by sending a written request to:

Patients' Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 6th Floor
Los Angeles, CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.